General

Guideline Title

U.S. medical eligibility criteria for contraceptive use, 2016.

Bibliographic Source(s)

Centers for Disease Control and Prevention (CDC). U.S. medical eligibility criteria for contraceptive use, 2016. MMWR Recomm Rep: Morb Mortal Wkly Rep. 2016 Jul 29;65(3):1-103. [12 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version:

Centers for Disease Control and Prevention (CDC). U.S. medical eligibility criteria for contraceptive use, 2010: adapted from the World Health Organization medical eligibility criteria for contraceptive use, 4th edition. MMWR Recomm Rep. 2010 Jun 18;59(RR-4):1-86. [969 references]

Centers for Disease Control and Prevention (CDC). Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of contraceptive methods during the postpartum period. MMWR Morb Mortal Wkly Rep. 2011 Jul 8;60(26):878-83. [10 references]

Centers for Disease Control and Prevention (CDC). Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of hormonal contraception among women at high risk for HIV infection or infected with HIV. MMWR Morb Mortal Wkly Rep. 2012 Jun 22;61:449-52. [8 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Note from the Centers for Disease Control and Prevention (CDC) and the National Guideline Clearinghouse (NGC): This guidance will be updated as new evidence becomes available. Please check the CDC's Division of Reproductive Health Web site for any changes that have been made to the recommendations since this guideline was published.

This document updates CDC's *U.S. medical eligibility criteria for contraceptive use, 2010* (U.S. MEC 2010), based on new evidence and input from experts. A summary of changes from U.S. MEC 2010 is provided in Appendix A of the original guideline document.

Notable updates include the following:

- Addition of recommendations for women with cystic fibrosis, women with multiple sclerosis, and women receiving certain psychotropic drugs or St. John's wort
- Revisions to the recommendations for emergency contraception, including the addition of ulipristal acetate
- Revisions to the recommendations for postpartum women; women who are breastfeeding; women with known dyslipidemias, migraine headaches, superficial venous disease, gestational trophoblastic disease, sexually transmitted diseases (STDs), and human immunodeficiency virus (HIV); and women who are receiving antiretroviral therapy

How to Use This Document

These recommendations are intended to help health care providers determine the safe use of contraceptive methods among women and men with various characteristics and medical conditions. Providers also can use the information in these recommendations when consulting with women, men, and couples about their selection of contraceptive methods. The tables in this document include recommendations for the use of contraceptive methods by women and men with particular characteristics or medical conditions. Each condition is defined as representing either an individual's characteristics (e.g., age or history of pregnancy) or a known preexisting medical or pathologic condition (e.g., diabetes or hypertension). The recommendations refer to contraceptive methods being used for contraceptive purposes; the recommendations do not consider the use of contraceptive methods for treatment of medical conditions because the eligibility criteria in these situations might differ. The conditions affecting eligibility for the use of each contraceptive method are classified into one of four categories (refer to Box 1 below).

Box 1. Categories of Medical Eligibility Criteria for Contraceptive Use

1 = A condition for which there is no restriction for the use of the contraceptive method.
2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.
3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.
4 = A condition that represents an unacceptable health risk if the contraceptive method is used.

Using the Categories in Practice

Health care providers can use the eligibility categories when assessing the safety of contraceptive method use for women and men with specific medical conditions or characteristics. Category 1 comprises conditions for which no restrictions exist for use of the contraceptive method. Classification of a method/condition as category 2 indicates the method generally can be used, although careful follow-up might be required. For a method/condition classified as category 3, use of that method usually is not recommended unless other more appropriate methods are not available or acceptable. The severity of the condition and the availability, practicality, and acceptability of alternative methods should be considered, and careful follow-up is required. Hence, provision of a contraceptive method to a woman with a condition classified as category 3 requires careful clinical judgement and access to clinical services. Category 4 comprises conditions that represent an unacceptable health risk if the method is used. For example, a smoker aged <35 years generally can use combined oral contraceptives (COCs) (category 2). However, for a woman aged ≥35 years who smokes <15 cigarettes per day, the use of COCs usually is not recommended unless other methods are not available or acceptable to her (category 3). A woman aged ≥35 years who smokes ≥15 cigarettes per day should not use COCs because of unacceptable health risks, primarily the risk for myocardial infarction and stroke (category 4). The programmatic implications of these categories might depend on the circumstances of particular professional or service organizations. For example, in some settings, a category 3 might mean that a special consultation is warranted.

The recommendations address medical eligibility criteria for the initiation and continued use of all methods evaluated. The issue of continuation criteria is clinically relevant whenever a medical condition develops or worsens during use of a contraceptive method. When the categories differ for initiation and continuation, these differences are noted in the Initiation and Continuation columns. When initiation and continuation are not indicated, the category is the same for initiation and continuation of use.

On the basis of this classification system, the eligibility criteria or initiating and continuing use of a specific contraceptive method are presented in tables (see Appendices A–K in the original guideline document). In these tables, the first column indicates the condition. Several conditions are divided into subconditions to differentiate between varying types or severity of the condition. The second column classifies the condition for initiation or continuation (or both) into category 1, 2, 3, or 4. For certain conditions, the numeric classification does not adequately capture the recommendation; in these cases, the third column clarifies the numeric category. These clarifications were determined during the discussions of the scientific evidence and are considered a necessary element of the recommendation. The third column also summarizes the evidence for the recommendation if evidence exists. The recommendations for which no evidence is cited are based on expert opinion from either the World Health Organization (WHO) or U.S. expert meeting in which these recommendations were developed, and might be based on evidence from sources other than systematic reviews. For certain recommendations, additional comments appear in the third column and generally come from the WHO

meeting or the U.S. meeting.

Recommendations for Use of Contraceptive Methods

The classifications for whether women with certain medical conditions or characteristics can use specific contraceptive methods are provided in several appendices in the original guideline document for the following contraceptive methods:

- Copper-containing intrauterine device (IUD) and levonorgestrel-releasing IUDs (Appendix B)
- Progestin-only contraceptives (POCs), including etonogestrel implants, depot medroxyprogesterone acetate injections, and progestin-only pills (Appendix C)
- Combined hormonal contraceptive (CHCs), including low-dose (containing ≤35 µg ethinyl estradiol) combined oral contraceptives (COCs), combined hormonal patch, and combined vaginal ring (Appendix D)
- Barrier contraceptive methods, including male and female condoms, spermicides, diaphragm with spermicide, and cervical cap (Appendix E)
- Fertility awareness–based methods (Appendix F)
- Lactational amenorrhea method (Appendix G)
- Coitus interruptus (Appendix H)
- Female and male sterilization (Appendix I)
- Emergency contraception, including emergency use of the copper-containing IUD and emergency contraceptive pills (Appendix J)

A table at the end of the original guideline document summarizes the classifications for the hormonal and intrauterine methods (Appendix K).

Contraceptive Method Choice

Many elements need to be considered by women, men, or couples at any given point in their lifetimes when choosing the most appropriate contraceptive method. These elements include safety, effectiveness, availability (including accessibility and affordability), and acceptability. The guidance in this report focuses primarily on the safety of a given contraceptive method for a person with a particular characteristic or medical condition. Therefore, the classification of category 1 means that the method can be used in that circumstance with no restrictions with regard to safety but does not necessarily imply that the method is the best choice for that person; other factors, such as effectiveness, availability, and acceptability, might play an important role in determining the most appropriate choice. Voluntary informed choice of contraceptive methods is an essential guiding principle, and contraceptive counseling, when applicable, might be an important contributor to the successful use of contraceptive methods.

In choosing a method of contraception, dual protection from the simultaneous risk for human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs) also should be considered. Although hormonal contraceptives and IUDs are highly effective at preventing pregnancy, they do not protect against STDs, including HIV. Consistent and correct use of the male latex condom reduces the risk for HIV infection and other STDs, including chlamydial infection, gonococcal infection, and trichomoniasis. Although evidence is limited, use of female condoms can provide protection from acquisition and transmission of STDs. All patients, regardless of contraceptive choice, should be counseled about the use of condoms and the risk for STDs, including HIV infection. Additional information about prevention and treatment of STDs is available from the CDC's *Sexually Transmitted Diseases Treatment Guidelines* (http://www.cdc.gov/std/treatment).

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Unintended pregnancy

Guideline Category

Assessment of Therapeutic Effectiveness

Counseling

Evaluation

Management

Prevention

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Infectious Diseases

Internal Medicine

Obstetrics and Gynecology

Pediatrics

Pharmacology

Preventive Medicine

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Other

Pharmacists

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

- To provide recommendations for the use of specific contraceptive methods by women and men who have certain characteristics or medical conditions
- To remove unnecessary medical barriers to accessing and using contraception, thereby decreasing the number of unintended pregnancies
- To update the Center for Disease Control and Prevention (CDC)'s *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010*, based on new evidence and input from experts

Target Population

Women and men with certain characteristics or medical conditions who are choosing a contraceptive method. These characteristics and conditions include the following:

- Personal characteristics and reproductive history
- Cardiovascular disease
- Rheumatic disease
- Neurologic conditions
- Depressive disorders
- Reproductive tract infections and disorders
- Human immunodeficiency virus (HIV) infection or risk for HIV infection
- Other infections
- Endocrine conditions
- Gastrointestinal conditions
- Cystic fibrosis
- Anemias
- Solid organ transplantation
- Drug interactions

Interventions and Practices Considered

1. Copper-containing intrauterine device (IUD) and levonorgestrel-releasing IUDs
2. Progestin-only contraceptives (POCs), including progestin-only implants, depot medroxyprogesterone acetate injections, and progestin-only pills
3. Combined hormonal contraceptive (CHCs), including low-dose (containing ≤35 μg ethinyl estradiol) combined oral contraceptives (COCs), combined hormonal patch, and combined vaginal ring
4. Barrier contraceptive methods, including male and female condoms, spermicides, diaphragm with spermicide, and cervical cap
5. Fertility awareness–based (FAB) methods
6. Lactational amenorrhea method (breastfeeding)
7. Coitus interruptus (withdrawal)
8. Sterilization: tubal sterilization for women and vasectomy for men
9. Emergency contraception, including emergency use of the copper-containing IUD and emergency contraceptive pills (ulipristal acetate, levonorgestrel, and combined oral contraceptives)

Major Outcomes Considered

- Effectiveness of contraceptive methods
- Safety of contraceptive methods
- Unintended pregnancy rate

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Since publication of *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010* (U.S. MEC 2010), the Centers for Disease Control and Prevention (CDC) has monitored the literature for new evidence relevant to the recommendations through the World Health Organization (WHO)/CDC continuous identification of research evidence (CIRE) system. This system identifies new evidence as it is published and allows WHO and CDC to update systematic reviews and facilitate updates to recommendations as new evidence warrants. Automated searches are run in PubMed weekly, and the results are reviewed. Abstracts that meet specific criteria are added to the Web-based CIRE system, which facilitates coordination and peer review of systematic reviews for both WHO and CDC.

CDC staff members and other invited authors conducted independent systematic reviews for each of the topics being considered for U.S. MEC 2016. The purpose of these systematic reviews was to identify direct evidence about the safety of contraceptive method use by women with selected conditions (e.g., risk for disease progression or other adverse health effects in women with multiple sclerosis who use combined hormonal contraceptives [CHCs]). The full reviews appear in the published literature and contain the details of each review, including the systematic review question, literature search protocol, inclusion and exclusion criteria, evidence tables, and quality assessments (see the "Availability of Companion Documents" field). CDC staff continued to monitor new evidence identified through the CIRE system during the preparation for the August 2015 meeting.

Number of Source Documents

A total of 15 systematic reviews were used for the 2016 guideline update. The tables in Appendices A-K in the original guideline document identify the source document for the recommendation if evidence exists.

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Weighting According to a Rating Scheme (Scheme Not Given)

Rating Scheme for the Strength of the Evidence

Strength and quality of the evidence were assigned using the system of the U.S. Preventive Services Task Force (2001).

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

In preparation for an expert meeting held during August 26 to 28, 2015, to review the scientific evidence for potential recommendations, Centers for Disease Control and Prevention (CDC) staff members and other invited authors conducted independent systematic reviews for each of the topics being considered. The purpose of these systematic reviews was to identify direct evidence about the safety of contraceptive method use by women with selected conditions (e.g., risk for disease progression or other adverse health effects in women with multiple sclerosis who use combined hormonal contraceptives [CHCs]). Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were followed for reporting systematic reviews, and strength and quality of the evidence were assigned using the system of the U.S. Preventive Services Task Force (USPSTF). When direct evidence was limited or not available, indirect evidence (e.g., evidence on surrogate outcomes or among healthy women) and theoretical issues were considered and either added to direct evidence within a systematic review or separately compiled for presentation to the meeting participants. Completed systematic reviews were peer reviewed by two or three experts and then provided to participants before the expert meeting. Reviews are referenced and cited throughout the original guideline document; the full reviews appear in the published literature and contain the details of each review, including the systematic review question, literature search protocol, inclusion and exclusion criteria, evidence tables, and quality assessments (see the "Availability of Companion Documents" field). CDC staff continued to monitor new evidence identified through the continuous identification of research evidence (CIRE) system during the preparation for the August 2015 meeting.

Methods Used to Formulate the Recommendations

Expert Consensus

Expert Consensus (Consensus Development Conference)

Description of Methods Used to Formulate the Recommendations

During August 27–28, 2014, the Centers for Disease Control and Prevention (CDC) held a meeting in Atlanta, Georgia, of 11 family planning experts and representatives from partner organizations to solicit their input on the scope of and process for updating both *U.S. Medical Eligibility Criteria for Contraceptive Use* (U.S. MEC) 2010 and *U.S. Selected Practice Recommendations for Contraceptive Use* (U.S. SPR) 2013. The participants were experts in family planning and represented various types of health care providers, as well as health care provider organizations. A list of participants is provided at the end of the original guideline document. Meeting participants discussed topics to be addressed in the update of U.S. MEC based on new evidence published since 2010 (identified through the continuous identification of research evidence [CIRE] system), topics addressed at a 2014 World Health Organization (WHO) meeting to update global guidance, and suggestions CDC received from health care providers for the addition of recommendations for women with medical conditions not yet included in U.S. MEC (e.g., from provider feedback through e-mail, public inquiry, and questions received at conferences). CDC identified several topics to consider when updating the guidance, including revision of existing recommendations for certain medical conditions or characteristics (breastfeeding, postpartum, human immunodeficiency virus [HIV], receiving antiretroviral therapy, obesity, dyslipidemia, increased risk for sexually transmitted diseases (STDs), superficial venous thrombosis, gestational trophoblastic disease, and migraine headaches), addition of recommendations for new medical conditions (cystic fibrosis, multiple sclerosis, use of certain psychotropic drugs, and St. John's wort), and addition of recommendations for new contraceptive methods (ulipristal acetate for emergency contraception). CDC determined that all other recommendations in U.S. MEC 2010 were up to date and consistent with the existing body of evidence for that recommendation.

During August 26–28, 2015, in Atlanta, Georgia, CDC held a meeting with 44 participants who were invited to provide their individual perspectives on the scientific evidence presented and potential recommendations. Twenty-nine of the participants represented a wide range of expertise in family planning provision and research, and included obstetricians/gynecologists, pediatricians, family physicians, nurse practitioners, epidemiologists, and others with research and clinical practice expertise in contraceptive safety, effectiveness, and management; these individuals participated in the entire meeting. Fifteen participants with expertise relevant to specific topics on the meeting agenda provided information and participated in the discussion (e.g., an expert in cystic fibrosis was asked to provide general information about the condition and to assist in interpreting the evidence and any theoretical concerns on the use of contraceptive methods in women with the condition); these participants provided input only during the session for which their topics were discussed. Lists of participants and any potential conflicts of interest are provided at the end of the original guideline document. During the meeting, the evidence from the systematic review for each topic was presented, including direct evidence and any indirect evidence or theoretical concerns. Participants provided their perspectives on using the evidence to develop recommendations that would meet the needs of U.S. health care providers. After the meeting, CDC determined the recommendations, taking into consideration the perspectives provided by the meeting participants.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Description of Method of Guideline Validation

Feedback was received from three external reviewers, composed of health care providers and researchers who had not participated in the update meetings. These reviewers were asked to provide comments on the accuracy, feasibility, and clarity of the recommendations. Areas of research that need additional investigation also were considered during the meeting.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The tables in Appendices A-K in the original guideline document summarize the evidence for the recommendation if evidence exists. The recommendations for which no evidence is cited are based on expert opinion from either the World Health Organization (WHO) or U.S. expert meeting in which these recommendations were developed, and might be based on evidence from sources other than systematic reviews. For certain recommendations, additional comments appear in the third column and generally come from the WHO meeting or the U.S. meeting.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- This evidence-based guidance will help health care providers offer quality family planning care to their patients, including choosing the most appropriate contraceptive method for individual circumstances and using that method correctly, consistently, and continuously to maximize effectiveness.
- These recommendations will assist health care providers when they counsel women, men, and couples about contraceptive method choice.

Refer to Appendices A through K of the original guideline document for benefits of specific contraceptive methods.

Potential Harms

The risks associated with use of various contraceptive methods in individuals with specific medical conditions or characteristics (including potential for drug interactions) are summarized in Appendices A through K of the original guideline document.

Contraindications

Contraindications

- The intrauterine device (IUD) is not indicated during pregnancy and should not be used because of the risk for serious pelvic infection and septic spontaneous abortion.
- Breastfeeding is not recommended for 24 hours after taking ulipristal acetate (UPA) because it is excreted in breast milk with highest concentrations in the first 24 hours, and maximum maternal serum levels are reached 1 to 3 hours after administration. Mean UPA concentrations in breast milk decrease markedly from 0 to 24–48 hours and then slowly decrease over 5 days. Breast milk should be expressed and discarded for 24 hours after taking UPA.
- The diaphragm cannot be used in certain cases of prolapse. Cap use is not appropriate for a woman with markedly distorted cervical anatomy.

Qualifying Statements

Qualifying Statements

- These recommendations are meant to serve as a source of clinical guidance for health care providers; health care providers should always consider the individual clinical circumstances of each person seeking family planning services. This report is not intended to be a substitute for professional medical advice for individual patients, who should seek advice from their health care providers when considering family planning options.
- Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.
- References to non-Centers for Disease Control and Prevention (CDC) sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in the *MMWR* were current as of the date of

publication.

- This document will not include any discussion of the unlabeled use of a product or a product under investigational use, with the exception that some of the recommendations in this document might be inconsistent with package labeling.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Mobile Device Resources

Patient Resources

Resources

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Centers for Disease Control and Prevention (CDC). U.S. medical eligibility criteria for contraceptive use, 2016. MMWR Recomm Rep: Morb Mortal Wkly Rep. 2016 Jul 29;65(3):1-103. [12 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2016 Jul 29

Guideline Developer(s)

Centers for Disease Control and Prevention - Federal Government Agency [U.S.]

Source(s) of Funding

United States Government

Guideline Committee

Centers for Disease Control and Prevention (CDC) Guideline Development Group for *U.S. Medical Eligibility Criteria for Contraceptive Use* and *U.S. Selected Practice Recommendations for Contraceptive Use*

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Disclosure of Relationship

The Centers for Disease Control and Prevention (CDC), its planners, and its content experts wish to disclose they have no financial interest or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. Planners have reviewed content to ensure there is no bias. This document will not include any discussion of the unlabeled use of a product or a product under investigational use, with the exception that some of the recommendations in this document might be inconsistent with package labeling.

Handling Conflicts of Interest

To promote transparency, all participants were asked to disclose any potential conflicts of interest to CDC prior to the expert meeting and to report any potential conflicts of interest during the introductory portion of the expert meeting. All potential conflicts of interest are listed in the original guideline document. No participants were excluded from discussion based on potential conflicts of interest. CDC staff who ultimately decided and developed these recommendations have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters relevant to these recommendations.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version:

Centers for Disease Control and Prevention (CDC). U.S. medical eligibility criteria for contraceptive use, 2010: adapted from the World Health Organization medical eligibility criteria for contraceptive use, 4th edition. MMWR Recomm Rep. 2010 Jun 18;59(RR-4):1-86. [969 references]

Centers for Disease Control and Prevention (CDC). Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of contraceptive methods during the postpartum period. MMWR Morb Mortal Wkly Rep. 2011 Jul 8;60(26):878-83. [10 references]

Centers for Disease Control and Prevention (CDC). Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of hormonal contraception among women at high risk for HIV infection or infected with HIV. MMWR Morb Mortal Wkly Rep. 2012 Jun 22;61:449-52. [8 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Centers for Disease Control and Prevention (CDC) Web site .

Availability of Companion Documents

The following are available:

- Berry-Bibee EN, Kim MJ, Simmons KB, Tepper NK, Riley HE, Pagano HP, et al. Drug interactions between hormonal contraceptives and psychotropic drugs: a systematic review. Contraception. 2016 Dec;94(6):650-67.
- Berry-Bibee EN, Kim MJ, Tepper NK, Riley HE, Curtis KM. Co-administration of St. John's wort and hormonal contraceptives: a systematic review. Contraception. 2016 Dec;96(6):668-77.
- Berry-Bibee EN, Tepper NK, Jatlaoui TC, Whiteman MK, Jamieson DJ, Curtis KM. The safety of intrauterine devices in breastfeeding women: a systematic review. Contraception. 2016 Dec;94(6):725-38.
- Dragoman M, Curtis KM, Gaffield ME. Combined hormonal contraceptive use among women with known dyslipidemias: a systematic review of critical safety outcomes. Contraception. 2016 Sep;94(3):280-87.
- Gaffield ME, Kappa N, Curtis KM. Combined oral contraceptive and intrauterine device use among women with gestational trophoblastic disease. Contraception. 2009 Oct;80(4):363–71.
- Jatlaoui TC, Curtis KM. Safety and effectiveness data for emergency contraceptive pills among women with obesity: a systematic review. Contraception. 2016 Dec;94(6):605-11.
- Jatlaoui TC, Riley H, Curtis KM. Safety data for levonorgestrel, ulipristal acetate and Yuzpe regimens for emergency contraception. Contraception. 2016 Feb;93(2):93-112.
- Jatlaoui TC, Simmons KB, Curtis KM. The safety of intrauterine contraception initiation among women with current asymptomatic cervical infections or at increased risk of sexually transmitted infections. Contraception. 2016 Dec;94(6):701-12.
- Phillips SJ, Tepper NK, Kapp N, Nanda K, Temmerman M, Curtis KM. Progestogen-only contraceptive use among breastfeeding women: a systematic review. Contraception. 2016 Sep;94(3):226-52.
- Tepper NK, Curtis KM, Nanda K, Jamieson DJ. Safety of intrauterine devices among women with HIV: a systematic review. Contraception. 2016 Dec;94(6):713-24.
- Tepper NK, Marchbanks PA, Curtis KM. Superficial venous disease and combined hormonal contraceptives: a systematic review. Contraception. 2016 Dec;94(3):275-9.
- Tepper NK, Phillips SJ, Kapp N, Gaffield ME, Curtis KM. Combined hormonal contraceptive use among breastfeeding women: an updated systematic review. Contraception. 2016 Sep;94(3):262-74.
- Tepper NK, Whiteman MK, Zapata LB, Marchbanks PA, Curtis KM. Safety of hormonal contraceptives among women with migraine: a systematic review. Contraception. 2016 Dec;94(6):630-40.
- Whiteman MK, Oduyebo T, Zapata LB, Walker S, Curtis KM. Contraceptive safety among women with cystic fibrosis: a systematic review. Contraception. 2016 Dec;94(6):621-9.

- Zapata LB, Oduyebo T, Whiteman MK, Houtchens MK, Marchbanks PA, Curtis KM. Contraceptive use among women with multiple sclerosis: a systematic review. Contraception. 2016 Dec; 94(6):612-20.

Available to subscribers from the Contraception Web site.

A summary chart of the *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016*, as well as additional implementation tools and resources including a mobile app, are available from the Centers for Disease Control and Prevention's (CDC's) Division of Reproductive Health Web site.

A continuing education examination is available from the CDC Web site.

Patient Resources

A Birth Control Methods Fact Sheet is available from the Womenshealth.gov Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on February 9, 2011. The information was verified by the guideline developer on March 1, 2011. This summary was updated by ECRI Institute on August 23, 2011 and August 3, 2012. This summary was updated by ECRI Institute on January 18, 2017.

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